12/24/08 rd accepted B. Coleman Letterhead

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295043	A. BUILDING _____ B. WING _____	C 11/14/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES	3101 PLUMAS RENO, NV 89509

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 19948 This Statement of Deficiencies was generated as a result of the complaint investigation conducted at your facility on 10/17/08 and finalized on 11/14/08. Complaint #NV00019407 was substantiated. See Tag F325. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.	F 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.	
F 325 SS=D	483.25(i) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Surveyor: 19948 Based on record review and interviews, the facility failed to monitor and assess that a resident's family was no longer assisting with meals as before in order to provide additional assistance with eating to prevent a significant weight loss for	F 325		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deborah Payne | TITLE: Administrator | (X6) DATE: 12/15/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 325	Continued From page 1 one resident. (#1) Findings include: Resident #1 was admitted to the facility on 6/10/08 from a acute care facility where she had been hospitalized for a fractured hip. She developed a wound infection in the operative site. Resident #1 was five feet eight inches tall. Her admission weight was 175 pounds. Her family stated that her normal weight was approximately 160 pounds. She was placed on a regular diet. A Nutrition Risk Assessment completed on 6/16/08 documented that the resident was in a high overall risk category. The Admission Minimum Data Set (MDS) completed on 6/23/08 identified that Resident #1 needed extensive assistance with eating and left 25% or more of food uneaten at most meals. The food intake records for June 2008 confirmed that the resident's intake varied from 5-90%. On 7/3/08 Resident #1 weighed 170.1 pounds. A Medicare 30 day MDS completed on 7/10/08 documented that the resident continued to need extensive help with eating. There was no documentation of a weight change or oral problems. The ADL (Activities of Daily Living) Worksheet completed by the Certified Nursing Assistants (CNA) documented the resident was independent and needing no help or staff oversight in eating. Her food intake remained from 15-80%. There was no evidence that the resident was seen by the dietician in July. It was noted that the resident did start in the restorative dining room on 7/8/08.	F 325	The facility will ensure residents will maintain acceptable weight parameters and avoid significant weight loss in residents who have families that assist in the dining experience. 1. Resident #1 is no longer at the facility. 2. Residents being assisted at meal times by family members will be identified by observations at meal times. 3. The licensed nurse will monitor residents that require assistance with meals. If the family member is not present, the licensed nurse will assign an employee to provide assistance to the resident. Licensed nurses will be re in serviced to this protocol.	12/26/08 12/26/08 12/26/08

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F 325	Continued From page 2 On 8/5/08 her weight remained consistent at 170 lbs. The Medicare 60 day MDS completed on 8/12/08 noted the resident to be independent after set up in eating. The ADL worksheet for August concurred that Resident #1 was independent in eating. Her food intake was consistently below 70%. There was no documentation of any interaction with the dietician for the month of August. On 9/5/08 Resident #1 weighed 134.8 pounds. A a reweigh was the same. The 35.2 pound loss or a 20.7% loss was significant. In a progress note from the physician dated 9/11/08, he wrote "if indeed her weight is dropping, we will look into it." A referral was made to the dietician and the resident was assessed on 9/12/08. It was noted that there was an absence of hunger and a refusal to eat. Actions taken included Megace, an appetite stimulator, enhanced milk and a magic cup. Her food preferences were updated, weekly weights were instituted and the care plan was updated. Nursing made the statement that comfort care seemed appropriate. The September ADL Worksheet continued to identify the resident as being independent in eating after setup. The Food Intake Record indicated some refusal of meals and with less than 40% consumed at many meals. The original care plan was developed for a potential for weight loss on 6/16/08 with a revision on 9/12/08. In an interview with the dietician on 10/17/08, she stated that staff were not aware of the weight loss until Resident #1 was weighed. No additional laboratory tests had been completed that would have alerted staff to nutritional changes or needs. There was no documentation of hydration concerns. When	F 325	4. The dining room hostess will complete the "dining room observation checklist" daily to include dining rooms for three meals, and room trays on a weekly basis. 5. Problems identified will be brought to the attention of the ADNS for immediate intervention. If trends identified, will be forwarded to QAA by ADNS.	12/26/08 12/26/08

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F 325	Continued From page 3 interviewing the Director of Nursing, on 10/17/08, he indicated that the resident had some change in behaviors, screaming out and an increase in confusion within the last month. The resident's physician stated during an interview on 10/17/08 at 1:20 PM, that when Resident #1 was first admitted, she required intensive wound care and responded poorly to attempts at rehabilitation. He further stated that staff felt that the resident's daughter was assisting with her eating, probably hand feeding her, more than they realized. When the daughter returned to her teaching position, she could not be present as often at meal times and the staff did not recognize that the resident needed additional help, such as prompting or being fed.	F 325		